



Authorization Number: _____
 (Valid for 90 days from date of request)

Prior Authorization Request

For Inpatient Fax to: 352-616-0946
 For Outpatient Fax to: 352-515-5975

STANDARD
 RETROSPECTIVE
 EXPEDITED
 Select EXPEDITED ONLY if the Member's life, health, or ability to regain maximum function is jeopardized.
 For authorizations that need IMMEDIATE response (Urgent), please call (888) 657-4171.

Member Information

Member ID: _____ Request Date: ____ / ____ / ____
 Member Last Name: _____ Member First Name: _____
 Member Phone Number: _____ - _____ - _____ Date of Birth: ____ / ____ / ____

Requesting Provider

Tax ID# _____ and NPI#: _____ Type: PCP Specialist* Other
 Provider Last Name: _____ Provider First Name: _____
 Phone Number: _____ - _____ - _____ Fax Number: _____ - _____ - _____
 Contact Name: _____ *Has PCP approved this request? Yes No I'm the PCP

Referred To and Servicing Providers

Practitioner Name: _____ **OON Reason:** _____
Specialty: _____ **Tax ID#** _____ **and NPI#:** _____
Address: _____ **Contact Name:** _____
Phone Number: _____ - _____ - _____ **Fax Number:** _____ - _____ - _____

Facility Name: _____ **OON Reason:** _____
Facility Type: _____ **Tax ID#** _____ **and NPI#:** _____
Address: _____ **Contact Name:** _____
Phone Number: _____ - _____ - _____ **Fax Number:** _____ - _____ - _____

Service Requested and Place of Service (POS)

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> In-Office/Diagnostic Center POS 11 | <input type="checkbox"/> Outpatient Hospital POS 22 | Therapy Services - In-Home | Therapy Services - Outpatient |
| <input type="checkbox"/> Dialysis POS 65 | <input type="checkbox"/> Inpatient Hospital POS 21 | <input type="checkbox"/> Physical Therapy POS 12 | <input type="checkbox"/> Physical Therapy POS 62 |
| <input type="checkbox"/> DME POS 12 | <input type="checkbox"/> Ambulatory Surgery Center POS 24 | <input type="checkbox"/> Occupational Therapy POS 12 | <input type="checkbox"/> Occupational Therapy POS 62 |
| <input type="checkbox"/> Home Health POS 12 | | <input type="checkbox"/> Speech Therapy POS 12 | <input type="checkbox"/> Speech Therapy POS 62 |
| <input type="checkbox"/> Transition of Care - All | | | |

Planned Date of Service: From: _____ To: _____ Scheduled Appointment Date: _____
 Primary ICD-10 Code: _____ Description: _____

CPT Code	Description	Part B Medication? If so, list units/Mg	Frequency	Total number of requested visits

Clinical Indication for request: _____

Payment is subject to verification of member eligibility, benefit coverage, and appropriate coding guidelines. Emergencies do not require prior authorization.
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